Copies of Email Attachments Sent In on the Subject of the Workers' Compensation Forums held in April, 2012

Part 1

Prepared by the Department of Industrial Relations

Note: Emails were sometimes sent prior to a Forum date, following a Forum date, and regardless of a sender's appearance at any particular Forum. What follows are attachments from emails received as PDFs, and are generally considered professional correspondence related to the public Forums; therefore, most of the attachments are not redacted.)

Claims Management, Inc.
P.O. Box 1288
Bentonville, AR 72712-1288
Phone 123.456.7890
Fax 123.456.7892

Department of Industrial Relations
& Division of Workers' Compensation

March 19, 2012

Re: DIR/DWC Forum

To Whom It May Concern,

Claims Management, Inc., also known as Arkansas Claims Management, Inc. ("CMI"), is the administrator of Workers' Compensation claims for Wal-Mart Stores, Inc. and its subsidiaries and affiliates and their insurers. I am writing in response to the Workers Compensation public forum concerning identification of appropriate fee schedules and reducing the burden of liens on the system.

In regards to appropriate fee schedules, California Workers Compensation fee schedule is currently based on Medicare plus a mark up or specific formula. We would like to suggest that the DWC look at adopting some of Medicare's methodology.

Currently, Hospitals and Ambulatory Surgery Centers are paid at 120% of Outpatient Prospective Payment System (OPPS) for Surgery and Emergency department visits. All other services are carved out to pay at the CA fee schedule. We would like to recommend adopting rules for OPPS for all Hospital and ASC services. I would recommend excluding the OPPS outlier formula as adopting full OPPS should be a fair rate and increase for the providers without the outlier which would most like increase fees tremendously.

Inpatient hospitals have been updated, and we have no recommendations on changes.

Remove the "exempt from the fee schedule status" for hospitals/services such as critical care hospitals, long term hospitals, rehab facilities, and skilled nursing facilities. We would like to recommend Medicare methodology for these services, like a percentage of Medicare, the Medicare Long term formulation, Medicare Rehab formulation, and/or the Medicare skilled nursing formula.

The current CA physician fee schedule pays at the reimbursement of the OMFS 2003 reduced by 5%, except those procedures that are between 100% and 105% of the Medicare rate, so payment will not fall below the Medicare rate. I recommend consideration be given to adopting the current CPT codes/fee schedule for Medicare and continue to pay Medicare value along with the adoption of the Medicare guidelines, NCCI edits, and the National physician fee schedule coding edits. This would give values to all services performed, including new codes that are not found in the current CA fee schedule. DWC could consider adding some of their own rules or regulations to the Medicare methodology such as limits of physical therapy, for example, 60 minutes a day and/or not more than 4 codes per day. Medicare has time unit methodology which might be more difficult to apply.

The reports section could change to an initial report, subsequent (every 45 days only), and final report since the progress reports are billed often and should be inclusive in the Evaluation and Management service being billed. Impairment reports/P&S and any special reports should be paid separately, but consider discontinuing payment for all other reports as updating to current Medicare should improve the provider's payment; therefore, this service should be inclusive.

Lab and Pathology, DMEPOS and Ambulance have been updated and we have no recommended changes for these areas.

EXPRESS SCRIPTS®

April 6, 2012

Ms. Rosa Moran
Administrative Director, Division of Workers' Compensation
1515 Clay Street, 6th Floor
Oakland, CA 94612

RE: Public Forum on Workers' Compensation

Dear Ms. Moran:

Express Scripts appreciates the opportunity to provide input and recommendations to the California Department of Industrial Relations (DIR) and Division of Workers' Compensation (DWC) through the public forums scheduled throughout the month of April. Express Scripts provides pharmacy benefit management services for many workers' compensation payers in California, providing us with experience and insight into some of the challenges and opportunities faced in the workers' compensation system.

Express Scripts has identified the following areas of opportunity in the California workers' compensation system based on our experience in addition to feedback from our clients and participating pharmacies:

- Pharmacy Benefit Networks (PBNs)

  The DWC had initiated discussions regarding possible regulation of PBNs in late 2009 with the last formal discussion taking place in March 2010. Since that time, there has been little direction provided by the DWC to direct payers on how to implement and manage a PBN. In November 2010, Express Scripts, in collaboration with CompPharma (consortium of workers' compensation PBMs), met with the DWC and received feedback indicating the PBN proposal would not be pursued by the DWC. Instead, insurers that wanted to establish more controls around network adherence were encouraged to review the Medical Provider Network (MPN) guidelines which allow for the insurer to list their network pharmacies as ancillary providers. The DWC provided Express Scripts and CompPharma with written confirmation on this item as well on December 1st, 2010. In order to ensure all parties are clear on the DWC's intent, we recommend this topic be addressed during the public forums.

- MediCal Based Fee Schedule

  The California workers' compensation fee schedule is based on the MediCal reimbursement rates which used the First DataBank Average Wholesale Price

(AWP) to establish the MediCal MAC price. In September 2011, First DataBank ceased publishing AWP as a result of a lawsuit. As a result, the MediCal MAC price has not been updated since September 2011 as MediCal works to update the MAC rates until another pricing benchmark (Average Acquisition Cost – AAC) can be established.

MediCal announced they would have updated pricing at the end of February; however, the DIR pharmacy fee schedule website (http://www.dir.ca.gov/dwc/pharmfeesched/pfs.asp) has not yet been updated with new MediCal rates. Furthermore, MediCal announced that once the updates were complete, pharmacies dispensing prescriptions for their patients would be made whole. The challenge this poses is two-fold: pharmacies believe they are being underpaid for prescriptions, and workers' compensation payers face a significant challenge with repricing all of the prescriptions processed from September 2011 to current (once the MediCal rates are updated).

While patients covered under MediCal have one payer (the State of California), injured workers are covered by many payers who must apply any adjustments at the individual claim level resulting in the process of identifying over or under payments extremely cumbersome and administratively burdensome. Express Scripts requests the DWC consider enacting legislation to prospectively address MediCal rate changes rather than requiring a retrospective application of the MediCal rates which in turn drives up costs in administering claims in addition to creating a need for clarity surrounding how such corrections should be reported to the State as required by EDI reporting.

- Electronic and Standardized Billing Regulations

  The DWC adopted paper billing regulations effective October 15, 2011, requiring payment of paper bills within 45 working days after receipt of a bill, while electronic billing regulations, effective October 18, 2012, require payment within 15 working days of receipt of the bill. Express Scripts recognizes that a decreased turnaround time for bill payment on electronically submitted prescriptions provides incentives for providers to bill electronically; however, a 15 working day period does not provide sufficient time for payers to process the payments and apply at the individual claim level. As a result, Express Scripts requests the DWC consider modifying the payment period for electronically submitted bills from 15 working days to 20 working days, allowing for the continued incentive to providers to bill electronically while also allowing payers with a reasonable timeframe for processing payment.

- Narcotics and Opioid Utilization

  Narcotics and opioid use have been a source of concern across the nation as addiction and accidental death resulting from the use of these powerful medications has been publicized. PBMs can provide clients with tools and programs to manage utilization of narcotics and opioids. In November 2010,

Express Scripts, in conjunction with CompPharma, met with the DWC to discuss utilization review (UR) as it relates to prescriptions. During this discussion, we asked for clarification as to how the proposed changes would impact PBM clients. At that point, the DWC shared that insurance carriers who have an established PBM and agreed upon plan design with a drug list in place would be in compliance with the current utilization review requirements in the DWC regulations.

Furthermore, the DWC shared that the regulations allow insurance carriers and providers to make agreements regarding what is authorized without going through UR. The DWC refers to this as "prior authorization." The DWC further shared that "The UR plan does need to state what the agreement is: "Each utilization review process shall be set forth in a utilization review plan which shall contain: "... a description of the claims administrator's practice, if applicable, of any prior authorization process, including but not limited to, *where authorization is provided without the submission of the request for authorization.*" (Emphasis added) (8 CCR § 9792.7(a)(5))."

Express Scripts requests the DWC provide clarification during the public forums regarding the ability for a payer to enlist the services of a PBM to assist in managing prescription utilization, allowing for safety programs to be used in managing the use of narcotics and opioids and while driving waste out of the California workers' compensation system.

Express Scripts appreciates the opportunity to provide feedback as the DWC considers possible changes to the workers' compensation system in California. Please feel free to contact Kristi Armijo (karmijo@express-scripts.com or 480.736.3172) if Express Scripts can provide additional insight or assistance as the DWC works to address pharmacy topics.

Sincerely,

Kristi Armijo

Kristi Armijo
Director, Compliance and Strategic Initiatives

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April 6, 2012

Christine Baker, Director
Department of Industrial Relations
455 Golden Gate Avenue
San Francisco, CA 94102

Email: DIR@dir.ca.gov

RE: Support passage of SB 923 and update Workers' Compensation Fee Schedule

Dear Ms. Baker:

On behalf of PTPN, the nation's oldest and largest network of private practice therapists, with over 300 independently owned physical, occupational and speech language therapy practices in California, I urge you to update the workers' comp. fee schedule and support SB 923.

PTPN worked closely with the DWC in 2009 and 2010 to update the fee schedule to an RBRVS system and to make sure that the result was appropriate to therapy services, which make up a large portion of the dollars expended in California on workers' comp. We were quite dismayed when this effort stalled out. Updating the fee schedule will improve access to high quality medical care for injured workers by attracting and retaining high quality therapy providers. These providers get injured workers' back to work more quickly, thereby reducing overall medical costs, saving money for the state and the taxpayer, and benefiting all of California's injured workers.

PTPN is unique in two ways. First, we are the only network of our kind that measures physical therapy outcomes through an independent third party, and has data to prove that therapy providers who get better outcomes also treat patients more efficiently (i.e. better outcomes per visit in fewer visits). Second, PTPN works with providers and employers to get injured workers treated quickly through our AccessPoint program where we set appointments and obtain authorization for workers' comp. treatment. We know from experience that more and more of our therapy offices are not treating workers' comp. patients because they simply cannot afford to treat them under a system that has not increased reimbursement in over a dozen years.

PTPN supports SB 923 which mandates the updating of the fee schedule by a date certain, but appropriately leaves the details of the RBRVS conversion, the selection of billing ground rules and coding guidelines, geographic adjustments, and other details to the regulatory process -- where they can be sorted through the deliberation and the input of stakeholder expertise.

I urge your support and leadership. Thank you for your consideration.

Sincerely,

PTPN

Nancy Rothenberg
Vice President

Medtronic

Dena Scearce, JD
Director, State Government Affairs

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dena.l.scearce@medtronic.com

April 3, 2012

The Honorable Rosa Moran, Administrative Director
Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

Submitted Via Email: DIR@DIR.ca.gov

Re: Separate Payment for Spinal Implants

Judge Moran:

We appreciate this opportunity to submit comments on current issues in California's workers' compensation system. Medtronic understands the goal in the state of California is to contain medical costs and generate savings, and we look forward to working with you and other stakeholders on alternatives that will ensure appropriate access to necessary surgical interventions for injured workers, yet will still generate savings for the workers' compensation program.

Under the current system, the separate implant payment ensures that hospitals are properly reimbursed for complex spine surgeries that typically require numerous implantable devices. Without this appropriate and needed reimbursement or something similar, we know, based on past events, hospitals will discontinue spine surgeries for workers if payment does not appropriately reimburse for the cost of the procedure and access to care will be hindered.

Medtronic's Spinal and Biologics division manufactures products that treat a variety of disorders of the spine. These products are utilized by spinal and orthopedic surgeons to treat patients and restore their quality of life. Medtronic contracts with hospitals for spinal implants without regard to any payer program. For example, the price that a hospital pays for an implant used in a case with a commercial payer is the same paid for a workers' compensation case. When implants are sold to hospitals, Medtronic has no idea which type of payer or patient will ultimately receive the implants.

The separate implant payment *originated* because hospitals were losing money on each complex spinal procedure. If the payment is eliminated and a comparable alternative is not enacted, history will be repeated, and California workers will be on the losing end. In the past, the Division of Workers' Compensation (DWC) has relied on a fiscal analysis by RAND (which is based on a report by Dalton et al.) in its proposal to eliminate the separate payment. Our position remains that this reliance is flawed because the Dalton report, the source of the underlying data, is based solely on Medicare information; workers' compensation data was not available. In addition, the data analysis conducted by RAND is based on an incorrect assumption that the use of an overall cost-to-charge ratio gives an accurate indication of a hospital's true cost for a case. The practical rationale is that this methodology works to allow injured workers access to the same level of care as any other patient.

The discussion concerning the elimination of the pass-through payment should also include the proposed decrease in the Medicare reimbursement multiplier. See Proposed § 9789.22(h). DWC indicated in its Statement of Reasons (December 2010) regarding the proposed reduction to the Inpatient Hospital Fee Schedule that a doubling of savings from year 2011 to 2012 on a per discharge basis could occur due to that proposed Medicare multiplier reduction. Unfortunately, the projected 'savings' from this reduction and from the separate payment elimination will come on the backs of the hospitals providing the complex spinal surgeries to injured workers, and will severely limit or extinguish their abilities to provide appropriate services to California workers. As we have mentioned, history has shown that services will be curtailed, and hospitals will choose not to schedule complex spinal procedures because of insufficient reimbursement.

We are happy to work with the DWC and other key stakeholders on possible workable alternatives that meet the goal of continuing access for all patients in California. Thank you for your consideration of our comments. If you have any questions, please feel free to contact me.

Sincerely,

Dena Scearce, JD
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CompPharma

April 9, 2012

Ms. Rosa Moran
Administrative Director, Division of Workers' Compensation
1515 Clay Street, 6th floor
Oakland, CA 94612-1402

RE: Public Forum on Workers' Compensation

Dear Ms Moran:

On behalf of CompPharma, I'd like to thank the California Department of Industrial Relations and Division of Workers' Compensation (DWC) for the opportunity to provide input and suggestions for improvements to the state's workers' compensation system. CompPharma is a national organization made up the largest workers' compensation pharmacy benefit managers (PBMs) in the industry. Nationally, our organization provides public policy makers with data, insight, and information necessary to create effective policies governing the provision of workers' compensation pharmacy services and pharmacy related issues.

A PBM is a specialized entity which manages prescription drug services for its clients, which are workers' compensation payers and can include insurance companies, third party administrators, state funds, and public/private self-insured employers. There are a number of benefits PBMs bring to the workers' compensation system. Most importantly, PBMs ensure injured workers' receive prescribed medications promptly by guaranteeing payment to the pharmacy at the point of sale. Additionally, PBMs control costs and ensure medication safety by controlling utilization, managing pharmacy benefit networks (PBNs), providing drug regimen/utilization review, offering mail-order services for critically injured workers needing long-term pharmaceutical therapies and improving patient safety through numerous and proprietary clinical services which detect potential drug interactions, duplicative medications and potential abuse of narcotics.

There are a number of factors that affect pharmacy in workers' compensation. As an organization with close ties to both pharmacy and insurance providers, and with the an overall mission of providing timely medication in a cost-effective manner, CompPharma and its members are uniquely positioned to provide information on all areas impacting pharmacy including fee-schedule, networks, cost drivers and the increasing use of opiates. CompPharma appreciates this opportunity to provide comments and insight on the current state of the California workers' compensation

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regulatory playing field and we strongly feel the following issues – if addressed properly – could lead to improvements in care for injured workers and cost savings for payers. CompPharma respectfully submits the following items for your consideration and looks forward to working with you and your staff on these issues in the future.

Pharmacy Networks

California Labor Code 4600.2 allows medicines to be provided to injured employees through a contract with a pharmacy benefit network. Payers contract with PBMs to perform a variety of functions, including providing a pharmacy network. The vast majority of pharmacies agree to be part of the approved network, and in exchange the pharmacies agree to accept a rate previously negotiated by a PBM with guaranteed payment at point of sale –the dispensing of the prescription. Absent this, a pharmacy would be left to determine eligibility and run the risk of not receiving payment and facing significant administrative costs. This system (utilization of PBNs) increases pharmacy participation in the workers' compensation system by both pharmacies and injured workers. In addition, self insured employers and carriers often enjoy cost savings via negotiated contracts at below fee-schedule rates and do not have to create additional systems to communicate with pharmacies in real time (which is provided through by PBM which manages the PBN). Together, all of this works to increase injured worker access and control costs.

Currently contracts between the payer, employer and pharmacy provider can specify terms of service, pricing and settlements, as long as they are consistent with the Labor Code, all other state laws and DWC regulations/guidelines. The DWC has the authority to promulgate regulations on PBMs and PBNs, and attempted to do so in 2010 draft regulations which were posted on their online forum for public review and comment. However, the DWC chose to remove these comments from the rule-making process and has not taken any further action to establish PBNs regulations to date. CompPharma encourages the DWC to establish guidelines or regulations on pharmacy networks that include a clear set of rules for how out-of network claims are handled and paid. We believe this would increase network usage, thereby reducing overall pharmacy costs and potential liens.

Utilization Management & Opioids

Several national and California specific studies continue to showcase how utilization – number of prescriptions and type of drugs prescribed – remains the main cost driver for workers' compensation pharmacy. Historically, utilization has been a much bigger contributor to overall drug cost than price, typically by a factor of four to one. PBMs perform a vital cost-saving role by managing utilization while simultaneously improving patient safety through clinical services which detect potential drug interactions, duplicative medications and potential abuse of narcotics.

At a payors request a PBM can provide both prospective and retrospective utilization review, checking for safety and efficacy concerns and offering solutions. Prospective review is used to control prescription transactions for a variety of reasons, such as a patient attempting to refill prescriptions too soon, a drug being prescribed which is not typically used to treat a work related injury, the drug is not related to patient's injury, the drug conflicts with another medication the

patient is taking or multiple/duplicate prescriptions for dangerous drugs or narcotics. Retrospective review involves routing scripts through proprietary systems to detect duplicative prescriptions and claims filed by a pharmacy, potentially addictive drugs, medications that may interact badly with each other or drugs which can worsen other medical conditions and fraud. These types of clinical review can save lives along with removing significant costs from the total pharmacy spend, but can only be provided on many levels by a PBM that has spent considerable amounts of time, effort and finances to understand the California market and implement these programs.

The California workers' compensation system could benefit further by making comprehensive drug management of prescriptions a priority. Unfortunately, PBMs are limited in their ability by the current fee-schedule which does not reflect the costs of these services. The simple reality is, in a better business climate, PBMs could further reduce overall costs and better target problem areas. California must re-examine pharmacy reimbursement policies and provide for additional reimbursement to aid in more comprehensive management of drug usage.

CompPharma recently conducted a survey of executives and senior management at workers' compensation payers about prescription drug management. The survey focused on PBM capabilities and program results, cost drivers and cost trends in pharmacy management in workers' compensation. We do this with the premise that regardless of impact of outside influences such as fee schedules, new drugs on market, or claim frequency, better programs properly implemented will deliver lower loss costs, which translate to lower costs to the system and better care for injured workers. This is the eighth year that the study has been conducted, and surprisingly we found this year that respondents judged opioids to be a highly significant problem and future concern, much higher than in previous years.

It is abundantly clear that opioid usage in general and specifically in the workers' compensation marketplace is a growing problem. PBMs can be part of this solution by providing services to screen for overuse, multiple prescriptions for the same medication, multiple prescribers or "doctor shopping" and fraud and alert the dispensing pharmacy to pause before dispensing these non-medically necessary prescriptions. Targeted utilization management is a key component to controlling opioid usage; however as noted previously; California must make these services a priority.

Fee-Schedule

Section 5307.1 of the Labor Code sets reimbursement for workers' compensation pharmacy services at "100% of the relevant Medi-Cal payment system" – and unfortunately does not consider the clear distinctions between Medi-Cal and workers' compensation pharmacy. Medi-Cal is the second largest General Fund program in the State, and in difficult fiscal times this is where the Legislature often looks for "savings" when attempting to balance the budget. Additionally, Medi-Cal covers a very large (nearly 19.7 percent of Californians) and vastly different patient population. It is also a "single-payor" operating model, while workers' compensation operates in an open, competitive market. Policy changes enacted through legislation are targeted at enhancing the Medi-Cal system

and reducing Medi-Cal budgetary costs, and do not take into consideration the impact on the workers' compensation system. This link (from 2003) has created incredible instability for entities involved in providing workers' compensation pharmacy services. Workers' Compensation pharmacy is unique in this respect, as all other provider groups in workers' compensation are tied to the Medicare reimbursement rate.

CompPharma has worked diligently with the Legislature and DWC to protect against the most recent reductions to Medi-Cal. However, it should be noted that when the two systems were linked, reimbursement was set at average wholesale price (AWP) minus 10 percent and the current rate is AWP minus 17 percent, with the secondary 7 percent reduction occurring in a budget trailer bill, with the sole intent of reducing general fund spending (which is not relevant to workers' compensation). In effect, pharmacy providers were hit twice by this action and the DWC had no authority to offset or prospectively examine the change and the impact to injured workers and pharmacy providers.

Another example of a Medi-Cal policy that is adversely impacting workers' compensation is the current temporary freeze of the Medi-Cal rate. The Department of Healthcare Services has indicated that when this freeze is over payment changes will be retrospective. This is a simple policy for Medi-Cal because it is a single payor model where the payor is also the regulating agency. This policy becomes much more complicated when you insert multiple payors, contracted rates, and separate state reporting (EDI) requirements. The provision of pharmacy services in workers' compensation has numerous levels all of which are being negatively impacted by the freeze and subsequently by the unfreeze.

Perhaps the largest change facing Medi-Cal that will impact workers' compensation is the move to change the reimbursement methodology from AWP to one based on the average acquisition cost (AAC). The purpose of AAC is to establish a transparent, timely and accurate pharmacy reimbursement system based on actual acquisition cost (invoice) data and a statistically validated cost of dispensing. However there are cost variables in workers' compensation that dramatically impact price and dispensing that will not be factored into a Medi-Cal based AAC – again showcasing the difference between Medi-Cal and workers' compensation pharmacy services.

CompPharma is not adverse to changes in fee-schedule. However, we strongly believe these changes should be examined and discussed in the context of the workers' compensation system and the impact to injured workers, providers and payors. CompPharma encourages the DWC to utilize their existing ability to establish a separate pharmacy fee schedule which both recognizes the differences of workers' compensation and utilizes the fee structure(s) and rules of the Medi-cal system. Absent a stand-alone fee schedule, the DWC should explore ways to protect against arbitrary budget related reductions and allow for discussion on major policy changes to the system prior to adoption.

Conclusion

Again, thank you for the opportunity to provide comments and suggestions to improve California's workers' compensation system. In summary, CompPharma encourages the DWC take the following action:

- Establish guidelines or regulations on pharmacy networks that include a clear set of rules for how out-of network claims are handled and paid. This would increase network usage, thereby reducing overall pharmacy costs and potential liens.
- Make comprehensive drug management a priority. This includes ensuring sufficient reimbursement for services. This will reduce overall costs and improve patient outcomes, including over usage and dependency of opioids.
- Establish a pharmacy fee schedule that utilizes the existing Medi-Cal fee structure, but recognizes the differences in the two systems.
- Until a workers' compensation specific fee-schedule is adopted, establish protections against arbitrary budget related reductions and allow for discussion on major policy changes to the system prior to adoption.

CompPharma looks forward to working with the DWC to improve California's workers' compensation system. We hope that we can serve as a resource to you on these and other issues related to pharmacy services.

Sincerely,

Joseph Paduda

Joseph Paduda
President, CompPharma

cc. Ms. Christine Baker

April 2, 2012

Ms. Rosa Moran
Administrative Director, Division of Workers' Compensation
1515 Clay Street, 6th floor
Oakland, CA 94612-1402

RE: Public Forum on Workers' Compensation

Dear Ms. Moran:

On behalf of PMSI, I'd like to thank the California Department of Industrial Relations and Division of Workers' Compensation (DWC) for the opportunity to provide input and suggestions for improvement to the state's workers' compensation system. PMSI has always welcomed working with the Division and Division staff and appreciates the constant openness and assistance in handling ongoing problems.

PMSI is a national provider of pharmacy services, including retail pharmacy services through our PBM Tmesys and mail-order pharmacy services solely for workers' compensation claimants. In California PMSI provides pharmacy services for numerous large and small insurers and self-insured employers, chief among them are Chartis, Sedgwick, Zenith, SCIF and the Los Angeles Unified School District.

By way of background, a PBM – which PMSI operates – is a specialized entity which manages prescription drug services for its clients, which are workers' compensation payors and can include insurance companies, third party administrators, state funds and public/private self-insured employers. There are a number of benefits PBMs bring to the workers' compensation system. Most importantly, PBMs ensure injured workers receive prescribed medications promptly by guaranteeing payment to the pharmacy at point of sale. Additionally, PBMs control costs and ensure medication safety by controlling utilization, managing pharmacy benefit networks (PBNs), providing drug regimen/utilization review, offering mail-order services for critically injured workers needing long-term pharmaceutical therapies, and improving patient safety through numerous and proprietary clinical services which detect potential drug interactions, duplicative medications and potential abuse of narcotics.

There are a number of factors that affect provision of pharmacy services in workers' compensation. As a provider of pharmacy services across California, and nationwide, and with close ties to both workers' compensation pharmacy providers and insurance providers, PMSI is uniquely positioned to provide information on all areas impacting pharmacy including the California fee schedule, utilization of networks, shifting cost drivers and the dangerous increase in the use of opiates.

PMSI appreciates this opportunity to provide comments and insight on the current state of the California workers' compensation regulatory environment, and we strongly feel the following issues – if addressed properly – could lead to improvements in care for injured workers and cost savings for payors and the state. PMSI respectfully submits the following items for your consideration and looks forward to working with you and your staff on these issues in the future.

Pharmacy Networks

California Labor Code 4600.2 allows medicines to be provided to injured employees through a contract with a pharmacy benefit network. Payors contract with PBMs to perform a variety of functions, including providing a pharmacy network. The vast majority of pharmacies agree to be part of the approved network, and in exchange the pharmacy agrees to accept a rate previously negotiated by a PBM with guaranteed payment at point of sale or dispense of prescription. Absent this, a pharmacy would be left to determine eligibility and run the risk of not receiving payment for drugs already dispensed. The current state of the system – unregulated utilization of PBNs – provides positive results and increases pharmacy participation in the workers' compensation system by both pharmacies and injured workers. In addition, self-insured employers and carriers enjoy cost savings via negotiated contracts and do not have to create additional systems to communicate with pharmacies in real time (which is provided by the PBM which manages the PBN). Together, all of this works to increase injured worker access and control pharmacy costs.

Currently contracts between the payor, employer and pharmacy provider can specify terms of service, pricing and reimbursements, as long as they are consistent with the Labor Code, all other state laws and DWC regulations/guidelines. PMSI believes the DWC has the authority to promulgate regulations on PBNs, and attempted to do so in 2010 draft regulations which were posted on the online forum for public review and comment. However, DWC chose to remove these from the rule-making process and has not taken any further action to establish PBN regulations to date. To the benefit of all system stakeholders, PMSI strongly encourages DWC to engage in rule-making on this issue and establish guidelines or regulations on pharmacy benefits networks that include a clear set of rules for provider and injured worker notification, ability to "direct" injured workers to utilize a network provider/pharmacy and how out-of-network claims are handled and reimbursed. PMSI believes this would increase network usage, thereby reducing overall pharmacy costs and potential liens.

Drug Utilization

Several national and California-specific studies continue to showcase how utilization – number of prescriptions and type of drugs prescribed – remains the main driver for workers' compensation pharmacy costs. Historically, utilization has been a much bigger contributor to overall drug cost than price, typically by a factor of four to one. To help combat this cost driver – where they can – PBMs offer a vital cost-saving role with their ability to review and manage drug utilization while simultaneously improving patient safety through clinical services which detect potential drug interactions, duplicative medications and potential abuse of narcotics.

At a payor's request, a PBM can provide both prospective and retrospective drug regimen and prescription regiment review, checking for safety and efficacy concerns and offering solutions. Prospective review can help control prescription transactions before they become an issue, such as a patient attempting to refill prescriptions too soon, a drug being prescribed which is not typically used to treat a work related injury and/or is not related to patient's injury, the drug conflicts with another medication the patient is taking, or there are multiple/duplicate prescriptions for dangerous drugs or narcotics. Retrospective review involves routing scripts through proprietary systems to detect duplicative prescriptions and claims filed by a pharmacy, potentially addictive drugs, medications that may interact badly with each other or drugs which can worsen other medical conditions, and, of course, prescription abuse and fraud. These types of clinical reviews can save lives and remove significant unnecessary costs from the total pharmacy spend. However, without operation of PBMs in the California marketplace, many of these services would dissipate as PBMs have spent considerable amounts of time, effort and finances to understand the California market and implement these programs.

Unfortunately, PBMs are limited in their ability by the current fee schedule which does not reflect the costs of these, and other critical, services which continue to **ensure** pharmacies participate and fill prescriptions for injured workers in California. The simple reality is, in a better business climate, PBMs could further reduce overall costs and better target problem areas. California must re-examine pharmacy reimbursement policies and provide for additional reimbursement to aid in the development and utilization of more comprehensive pharmacy-driven management of drug utilization to help lower costs.

Opioid Usage and Abuse

Based upon discussions with our clients and internal PMSI data, it is abundantly clear that opioid usage in general and specifically in the workers' compensation marketplace is a growing cost driver and safety issue for injured workers. PBMs can be part of this solution by providing services to screen for overuse, multiple prescriptions for the same medication, multiple prescribers or "doctor shopping" and fraud and then alert the dispensing pharmacy (and carrier) to pause dispensing of these non-medically necessary prescriptions. Targeted drug regimen management is a key component to controlling opioid usage; however, as noted previously, California must make these services a priority.

Pharmacy Fee Schedule & Medi-Cal Linkage

Section 5307.1 of the Labor Code sets reimbursement for workers' compensation pharmacy services at "100 percent of fees prescribed in the relevant Medi-Cal payment system" – and unfortunately does not consider clear distinctions between Medi-Cal and workers' compensation pharmacy services and patient populations. Medi-Cal is the second largest General Fund program in the State and, in difficult fiscal times, is where the Legislature often looks for "savings" when attempting to balance the state budget. Additionally, Medi-Cal covers a very large (nearly 19.7 percent of Californians) and vastly different patient population. It is also a "single-payor" operating model, while workers' compensation operates in an open, competitive multi-payor market. Policy changes enacted through legislation that are targeted at reducing Medi-Cal budgetary costs and that do not take into consideration the impact on the workers'

compensation system are one-sided and dangerous. The current reimbursement link (from 2003) has created incredible instability for all entities involved in providing workers' compensation pharmacy services. Workers' Compensation pharmacy is unique in this respect, as all other provider groups in workers' compensation are tied to the Medicare reimbursement rate and have received Medicare linked reimbursement increases since 2003.

Over the years, PMSI has worked diligently with the Legislature and DWC to protect against all – and the most recent – reductions to Medi-Cal and subsequent impact to workers' compensation pharmacy providers. However, it should be noted that when the two systems were linked, pharmacy reimbursement was set at average wholesale price (AWP) minus 10 percent and the current rate is AWP minus 17 percent, with the secondary 7 percent reduction occurring in a budget trailer bill, with the sole intent of reducing general fund spending (which is not relevant to workers' compensation). In effect, pharmacy providers were hit twice by this action and DWC maintains it has no authority to offset or prospectively examine the change and impact to injured workers and pharmacy providers.

AWP Freeze and Medi-Cal AAC Transition

Another example of a policy that will impact workers' compensation is the current temporary freeze of the Medi-Cal rate – due to AWP source transition and various administrative issues **only** impacting Medi-Cal. The Department of Healthcare Services has indicated that when this freeze is over payment changes will be retrospective. This is a simple policy for Medi-Cal because it is a single payor model where the payor is also the regulating agency. This policy becomes much more complicated when you insert multiple payors, contracted rates, and separate state reporting (EDI) requirements on each transaction/prescription dispensed and processed. The provision of pharmacy services in workers' compensation has numerous levels, all of which are being negatively impacted by the freeze and subsequent unfreeze.

Perhaps the largest change facing Medi-Cal that will unintentionally impact workers' compensation is the move to change the reimbursement methodology from AWP to one based on the average acquisition cost (AAC). The purpose of AAC is to establish a transparent, timely and accurate pharmacy reimbursement system based on actual acquisition cost (invoice) data and a statistically validated cost of dispensing for **Medi-Cal providers**. However, there are cost variables in workers' compensation that dramatically impact price and dispensing that **will not be** factored into a Medi-Cal based AAC rate – which again will be blindly forced upon workers' compensation pharmacy providers. Additionally, PMSI's internal data and knowledge of pricing/reimbursement methodologies points to a fact that differences between Medi-Cal and workers' compensation will cause an AAC pricing donut hole as not all drugs utilized in workers' compensation will be covered by the Medi-Cal AAC pricing database.

PMSI is not opposed to changes and updates in the pharmacy fee schedule and pharmacy pricing sources, as they are a necessary evolution of the pharmacy marketplace and provision of pharmacy services. However, we strongly believe these changes should be examined and debated in the context of the workers' compensation system and how these changes will impact the ability of providers and

other entities to continue participation in the marketplace and subsequent impact to access for injured workers – **and not during budget debates on the Medi-Cal pharmacy program.**

PMSI encourages the DWC to utilize their existing ability to establish a separate pharmacy fee schedule which both recognizes the differences of workers' compensation and utilizes the fee structure(s) and rules of the Medi-cal system. Absent a stand-alone fee schedule, the DWC should explore ways to protect against arbitrary budget-related reductions and allow for discussion on major policy changes to the system prior to blanket adoption.

Conclusion

Again, thank you for the opportunity to provide comments and suggestions to improve California's workers' compensation system. In summary, PMSI encourages the DWC take the following action:

- Establish guidelines or regulations on pharmacy networks that include a clear set of rules for injured worker/provider notification, ability to "direct" injured worker participation within the network, and how out-of network claims are handled and reimbursed. This would increase network usage, thereby reducing overall pharmacy costs and potential liens.
- Make comprehensive drug regimen management a priority, to include ensuring sufficient reimbursement for cost-saving services provided by PBMs. This will reduce overall system costs, improve patient outcomes, including over usage of and dependency on opioids, and increase safety.
- Establish a pharmacy fee schedule that utilizes the existing Medi-Cal fee structure but recognizes the differences in two systems and fairly reimburses workers' compensation pharmacy providers for their services.
- Until a workers' compensation specific fee schedule is adopted, establish protections against arbitrary budget related reductions and allow for discussion on major policy changes to the system prior to adoption.

As always, PMSI looks forward to working with the Division and Division staff to improve California's workers' compensation system. We hope to continue as a resource for you and your staff on these and any other workers' compensation pharmacy related issues.

Sincerely,

Kevin C. Tribout
Executive Director of Government Affairs

cc: Melissa Cortez-Roth
Ms. Christine Baker

GATEWAYS HOSPITAL
AND MENTAL HEALTH CENTER

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Los Angeles, CA 90026
Phone 323. 644. 2000
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April 12, 2012

Christine Baker
Director
Department of Industrial Relations
455 Golden Gate Avenue
San Francisco, CA 94102

RE: Support passage of SB 923 and update Workers' Compensation Fee Schedule

Dear Ms. Baker:

As a healthcare provider of mental health services in Los Angeles, I urge you to update the fee schedule for primary care services within California's workers' compensation system -- which is still based on an outdated model from the 1970's. Updating the fee schedule will improve access to high quality medical care for California workers injured on the job by retaining high quality primary care physicians.

As an employer of over 360 workers the ability to provide diagnosis, treatment, reporting, and case management services, I know that SB 923 will resolve both the availability and cost of care problems within the existing system.

Implementing a Resource Based Relative Value Scale (RBRVS) system, as proposed in SB 923, will help retain quality primary care physicians in the California system; and will control increasing costs and unnecessary medical expenses incurred by some physicians.

By reducing medical costs and increasing delivery of quality medical services in the state's workers' compensation system, SB 923 will benefit all of California's injured workers. Reducing costs associated with the state's workers' compensation system also saves money for the State and taxpayer. SB 923 is a win/win for injured workers, treating physicians, and the State budget!

Importantly, SB 923 appropriately leaves the details of the RBRVS conversion, the selection of billing ground rules and coding guidelines, geographic adjustments, and other details to the regulatory process -- where they can be sorted through the deliberation and the input of stakeholder expertise.

I urge your support and leadership. Thank you for your consideration.

Sincerely,

Mara Pelsman
Chief Executive Officer

William S. Morris, ATTORNEY
Certified Workers' Compensation Specialist - State Bar of California

Please reply to:
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Turlock, CA 95381-1640

Tel (209) 667-1948 - Fax (209) 667-8932
Service by Fax Not Accepted

April 17, 2012

STATEMENT OF WILLIAM S MORRIS

My name is William Morris. I represent injured workers. I am an Applicant's attorney.

My clients are from the central valley which is the agricultural bread basket of California. Most of my clients make less than $50,000 per year, and many of them are undocumented. The agricultural field is unique in that there is a great demand for plentiful, but cheap labor. I am always surprised when I find that I am representing a man that is feeding and sheltering a family for less than $10,000 per year, or I'm representing a woman that is holding down three or four full time seasonal jobs. Agricultural labor is strenuous, and the safety of the worker is not always a consideration.

I appreciate the opportunity to give my opinions with regard to the problems of the workers' compensation system with special attention to the debacle caused by SB 899. The concept of workers' compensation has been around for over 100 years in California, yet the system that had been initiated and tweaked for almost a century has now been delivered a sever blow by the concept of fixing what was not broken. SB 899 essentially threw the baby out with the bath wash. I do not consider it coincidental that the State of California is now having financial problems because I think much of the State's fiscal problems can find roots in SB 899. It is my intention to point out the financial effects of SB 899, the Court decisions interpreting SB 899, and the recent legislation immediately preceding SB 899.

THE REAL BASIS FOR WORKERS' COMPENSATION

I think it important to acquaint ourselves with the real reason the workers' compensation system was developed. It was not really a bargain to give the employee an expectation of certain benefits in exchange for the opportunity to get large sums from a lawsuit although that is the expected end result. It was to remove the burden of those employees being injured because of the industrial revolution from the backs of the taxpayer and place that burden upon the employer who could better control the workplace and determine his cost of goods and services to include the cost of the employer's injuring his own employees in producing those goods and services.

Every time the legislature decides that the government can assume the burden of taking care of an injured worker, it removes the incentive for the employer to insist upon a safe work place. It harms the budget of the State by requiring the taxpayer to assume the cost that is the responsibility of the employer because of the employer's decision to produce those goods and services.

SAVINGS IN WORKERS' COMPENSATION IS NOT INTUITIVE

The saving of costs within the workers' compensation system is not intuitive. The concept of fairness should be abandoned because it focuses one's attention upon incorrect principles. It is not fair that a worker who has ruptured a disk in his back because of the demands of his employment should receive the paltry sum that is awarded in the workers' compensation system. At the same time, back injuries are common in the agricultural field where a person's reduced earning capacity because of a lack of education can be balanced against the earning capacity associated with a strong back. The economics of society just can not support awarding a fair sum to all of those workers whose earning capacity is destroyed when their back gives out. There is a balancing of what the employee needs to compensate him for his loss of earning capacity against what society can afford to pay in order to provide the employer with an incentive to produce necessary goods and services.

TEMPORARY DISABILITY SHOULD NOT BE FORESHORTENED

To demonstrate how the principle of saving money in the workers' compensation system does not follow intuitive principles, one should consider the reduction of temporary disability benefits. One would intuitively expect that reducing the period of time that temporary disability indemnity is paid would result in a savings by foreclosing the payment of temporary disability benefits beyond an established period of time. It doesn't happen that way. Establishing a fixed period of time for the payment of temporary disability benefits establishes a bottom line cost for the insurance companies. They now just presume that every injured worker will be paid 104 weeks of temporary disability, and they forget about trying to save costs with regard to this line item. Check the statistics on this, and I think you will find that very few industrial injuries are resolved within the 104 week period as opposed to prior to the establishment of a temporary disability benefit. The insurance company is no longer motivated to get the injured worker back to work in a timely manner. Instead, the insurance company can exert its efforts in delaying and denying the provision of medical care.

This is a cruel weapon because sometimes medical care that is delivered quickly will have a beneficial effect that is lost when it is delayed. The delay makes the treatment unnecessary. Further, there is the consideration of economic pressure upon the injured worker. As the injured worker remains unable to return to the world of work because of the delay of medical treatment, he finds himself unable to pay the simple costs of living because of the elimination of the temporary disability benefit. The economic pressure thus compels the worker to accept substantially less than his entitlement merely because of the delay and lack of benefits or resources. This egregious abuse of the injured worker is caused by the cessation of the temporary disability benefit.

I'm not through, however, because when the temporary disability benefit is foreshortened, the injured worker becomes eligible for public benefits such as State Disability benefits paid for as a tax

upon the injured worker's salary or if the employee is able to work at something, unemployment benefits which are a tax against the employer's profits. Since the insurance company no longer has to pay temporary disability benefits, The State coffers have to pick up the slack, and the State has no ability to control this expenditure because it is the insurance company that is driving the cost by failing to provide timely medical treatment. Lastly, the State is losing tax revenue because the injured worker is not being returned to the world of work. Thus my original comment that to me, it is small wonder that the State is having financial problems following the passage of SB 899 and the related legislation.

My solution is that the opposite should be done. Not only should there be no limit to how long an injured worker should receive temporary disability benefits, but there should be an automatic increase in temporary disability benefits after two years to account for loss of wage increases an employee would ordinarily expect to receive if working, and to motivate the insurance company to provide expeditious and timely medical treatment.

THE AMA GUIDES IS AN EXPENSIVE SOLUTION

An obvious expense of SB 899 was the legislature's shirking of its responsibility under the constitution to do its own development of a system of benefits. It instead abdicated that responsibility in favor of the American Medical Association (AMA). The AMA has no responsibility to the government or the citizens of this State for what it does in producing its Guides, and there is already evidence that the part of the AMA responsible for producing the Guides has been invaded by insurance company shills. Further, the concept of impairment as defined by the AMA has no relationship to a person's ability to work, and the AMA Guides says so.

By the AMA definition, a person is not totally impaired until he is dead. A person's complete inability to work occurs far before that event, and an ability to work is not necessarily directly comparable to a person's impairment. Take for instance the fact that an AMA impairment related to a knee injury is determined by the amount of cartilage remaining without contemplation of a person's gait disturbance. The gait disturbance, however, is a much greater indicator of a person's ability to work. Luckily, doctors have realized this distinction, and have adapted by utilizing procedures that the Board has accepted as appropriate in the cases known as Almaraz/Guzman.

By deferring to the AMA, the legislature compelled every practitioner, judge, and participant in the workers' compensation system to buy a copy of the AMA Guides. Before SB 899 one could learn about workers' compensation disability by purchase a book from the State's printing office for $15. At the time of SB 899's passage, the AMA Guides cost about $370. By my calculation, that meant that the AMA received an influx of $300,000 from the practicing Applicant's attorneys alone. I think that the teachers' union could have designated a better use for that $300,000 than increasing the profits of the AMA. The AMA Guides is not an objective basis for determining

disability as represented by the insurance companies and other proponents of change. The descriptions of disabilities that had been established over almost 100 years of tweaking was well understood by the practitioners in the workers' compensation system, and they were no less objective than the AMA Guides have proven to be. A generous savings can still be had by eliminating utilization of the AMA Guides and returning to the descriptions of injuries that had served this state well for nearly 100 years.

THE DOCTORS CAN'T BE MADE TO COOPERATE WITH THE WORKERS' COMPENSATION SYSTEM

In determining how medical benefits should be delivered to the injured worker, the legislature failed to take into consideration the motivation and cooperativeness of the physicians. SB 899 fails to offer the physician a financial incentive to participate in the workers' compensation system. Instead, there are disincentives. The physician is required to accept less than he charges the open market, and the physician must cater to a complex system of permission and review that increases the physician's overhead and interferes with the proper delivery of medical treatment. I have had physicians decline to further treat my clients because their expertise in the delivery of medical treatment was delayed or declined by an adjuster. The explanation was that the physician could not adequately treat the patient's condition when his treatment decisions were being second guessed and not being timely followed. He therefore declined to treat at all. There are other physicians who simply decline to treat workers' compensation patients at all. As an aside, let me note that some of these physicians who decline to accept workers' compensation patients have been identified by workers' compensation insurance companies as members of the insurance companies' Medical Provider Network which really puts into question the credibility of the system as it now stands.

I remember having an informal discussion with a world renowned physician who was complaining to me and a defense attorney that the new system made it difficult for him to adequately treat workers' compensation patients, and that he was recently (at that time) approached by a physician who had graduated near the bottom of his medical school class to become a member of the other physician's new Utilization Review network. It seems that the other physician was making twice the income of this world renowned physician at this new enterprise. The utilization review process has set up a cottage industry in which the reviewing physicians are not accepted as the treating physician's peer, and with little wonder as I have had an anesthesiologist do a peer review of a request by an orthopedist for a dermatological consult. The reviewing physician is hired with the motivation to save the insurance company money by denying medical procedures. There is no motivation by the UR doctor to not deny a medical procedure other than his level of embarrassment. I have had denials of medical treatment that had already been approved by an Agreed Medical Evaluator; I have had denials of medical treatment for referral to a specialist to evaluate a condition because the condition had not yet been evaluated; I have had denials of post surgical leg braces because the type of brace had not been identified. The

reviewing physician creates an unacceptable interference by calling the treating physician at inappropriate times, and frequently. I recently conducted a deposition of a treating physician who alleged to me and the attending defense attorney that he received approximately five peer review calls a day as a regular circumstance.

SAVINGS IN UTILIZATION REVIEW IS A MYTH

I see no merit to Utilization Review. Any savings it allegedly incurs is a myth. Any allegation that proposes that Utilization Review saves money is either based upon the failure to provide adequate medical treatment thereby diverting the cost from medical treatment to the delivery of a disability benefit, or there has been an inadequate evaluation of all of the costs involved with the system. It should be eliminated in its entirety, especially the requirement for pre-authorization. At the most, I suggest that it could be utilized only as an excuse by the insurance company to justify its actions when called to account for failure to pay for a medical procedure. The success and relative expense of the medical procedure called into question should be considered significant factors in any litigation in order to reduce the "let's try it and see" scenario of medical treatment.

MEDICAL PROVIDER NETWORKS ARE FRAUDS

The Medical Provider Network is a fraud. Interpretation of the MPN statutes has resulted in the insurance company's entitlement to demand that a patient treat within the MPN network no matter the initial factors involved in the patient's medical treatment. Although the statutes require an insurance company to initially place a patient with a medical provider, it does not require the same initial placement when the insurance company merely demands a change of medical providers. I have a client that has been denied medical treatment for over two years because of this single issue. It has been litigated, and the Board has provided me with no satisfaction. I have attempted to prove that there are no physicians within the MPN that will accept my client as a patient, but the proving of a negative has been shown to be problematic. The insurance company provides me a list of physicians, and refuses to select one and schedule an appointment even when I have demanded that they do so. At trial, the insurance company presented a witness who had allegedly obtained the MPN contracts with the physician members of the MPN. When asked if it was a requirement of the MPN that the physicians agree to accept a referral, the witness snorted and said that no doctor would do that. In fact, few physicians accept referral from other physicians in the central valley.

I suggest that if the MPN does not require the physician to accept a referral, then it is a fake. In the central valley, most physicians will refuse to accept the problems established by a prior physician. In particular, an orthopedist will not accept a patient that has not completed treatment with a different orthopedist. There is small wonder that a physician will not accept the problems of a prior physician, and it is naïve of the legislature to think one would do so.

To remain in good standing within an MPN, the physician is required to treat the dollar rather than treat the patient. I can not understand how the legislature could believe that treating the dollar is an adequate way to accomplish the Constitutional mandate of workers' compensation. One way to treat the dollar that I have observed is to have the MPN physician provide treatment according to a certain protocol. If the patient fails to recover according to the protocol, then he is dismissed as cured, and his complaints, which are unchanged, are asserted to be something different, but not the same as the industrial injury for which he came to the MPN physician in the first place. This is not a provision of medical treatment. It is a commission of a fraud upon the injured worker and the system.

I can not see how an MPN can be made to work. I see much better that medical treatment should be handled on a case by case basis. There are those doctors, and we all know who they are, who over treat or who provide inadequate treatment. A proper method to avoid abuse of the system is to allow the parties to charge a physician with over treatment or inadequate treatment, and set up a system of holding a hearing to determine whether the charge has been properly brought. A record can be maintained of the number of valid and non-valid charges brought, and a system of adjustments to the physician's compensation based upon these charges can be derived. It is an abuse of the injured worker to allow those interested in the cost of medical treatment rather than the injured worker's welfare to be in control of the injured worker's medical treatment. The system should go back to allowing the injured worker the ability to select the physician with whom he gets the most benefit, and with whom the injured worker is most comfortable. I say that this is a procedure that would produce better results by fostering a rapport with the treating physician that would result in faster and more effective medical treatment thereby quickly returning the injured worker to work.

THE PANEL QME PROCESS IS BANKRUPT

The Panel QME process should also be abandoned as a wasteful delay of the delivery of benefits. I'm not certain of just how much the State of California is paying in salaries to have someone put together a piece of paper that contains a panel of three eligible QME doctors, but I fail to understand just why it takes six months to accomplish something that could be accomplished by playing a game of darts for half a minute. It could also be accomplished by putting together a roulette wheel for about $100. Even if there is some sort of balancing technique being utilized that isn't patently obvious, it would take no more than $5,000 to develop a sophisticated computer program that would accomplish all of the bells and whistles necessary to select three panel doctors in an instant. Besides the fact that it takes so long for a panel to be issued, there is the additional factor that whoever is selecting the panel doctors feels it is appropriate to substitute their own legal opinions in the place of that of a workers' compensation judge whose duty it is to determine whether a panel request was appropriately requested. This interference with due process causes great delay and necessitates the intervention of a

workers' compensation judge to order the issuance of a panel. No benefit is being provided by the panel QME system, and it is violating the Constitutional mandate that things be done expeditiously.

A further problem with the panel system is that the panels are structured into certain groups that are not always appropriate. For instance, a brain injury normally requires the expertise of a neuropsychologist, but I have experienced the problem that one can not get a neuropsychologist panel even when one is ordered by a workers' compensation judge. I have talked with evaluators who have advised that when they are evaluating pro-per injured workers they are restricted from doing what they feel is appropriate by the economic pressure of the insurance companies. For example, the principle known as Almaraz/Guzman is now a rule of law which should be contemplated by all evaluators without being asked. Otherwise, the pro-per injured worker is not getting the full due process rights an attorney would guarantee for a represented injured worker. Nevertheless, it has been reported to me that should an evaluator for a pro-per injured worker attempts to utilize the Almaraz/Guzman principle he can expect to receive telephone calls and have his fees threatened by representatives of the insurance company. If there is any more demanding evidence that injured workers should be represented by an attorney, I know of none.

There is no benefit being provided by the panel QME process. The detriment is that it facilitates the insurance companies' ability to violate injured workers' due process rights. It fails to provide adequate evaluators for all medical conditions that could occur, and it creates an excessive delay that can not justify the salaries being paid to support it. There is absolutely no reason why this procedure should not be abolished with a return to a procedure that allows the litigants to select their own experts.

THERE SHOULD BE A RE-EVALUATION OF THE QME PROCESS

I'm not finished with the QME process. I wonder if anyone has investigated whether money has been saved as a result of the institution of the QME process. When I first started in workers' comp, we had organizations like First Western Medical that trained their stable of doctors, and provided dictation services that resulted in a well prepared and justified medical report. The insurance companies took after these organizations with a vengeance and eventually got them eliminated. All that has occurred, however, is that the expense absorbed by First Western in the market economy has now been assumed by the State of California which provides training, supervision, and certification of QME's. I challenge that the system is better or that the money is well spent. In particular, I continue to get QME's who acknowledge that a person has sustained a cumulative trauma injury, but deny that it is an industrial injury because the exposure within the past year could not have been sufficient to cause the injury even though the actions being performed within the past year were deleterious. There are QME's who will refuse to provide an impairment rating simply because they have formed the legal opinion that an injury is not industrial. I have had a QME assert that a blister that admittedly formed as a result of repetitive use of a foot

pedal was a typical diabetic lesion so not industrial. Having to spend effort and time refuting these ignorant evaluators is not an expeditious delivery of benefits as mandated by the Constitution, and it is not due process for the poor pro-per injured worker who needs to have an attorney if he wants to obtain his true entitlements.

As an aside, I might point out at this point that Fresno is dominated by a group of orthopedists that travel to this location to perform evaluations, and who have the reputation in the Applicant's community to not perform adequate evaluations. These doctors claim to be independent evaluators, but none of them have registered with the City of Fresno for a business license as required by the Fresno laws. The QME process that was established to eliminate First Western is inadequate, and not worth the expense to the State of California that is required to keep it going. It results in a denial of due process. I believe an investigation of the expense to the State as opposed to the expense that was incurred in the market place will reveal that this procedure was a losing proposition. The QME process should be eliminated in its entirety, and injured workers' should be allowed to obtain their own experts in the same way as litigants are able in a civil court of law.

Respectfully Submitted

_____

William S. Morris

JESUIT RESTORATIVE JUSTICE INITIATIVE
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310-559-0777 - www.jrji.org

April 20, 2012

Christine Baker
Director
Department of Industrial Relations
455 Golden Gate Avenue
San Francisco, CA 94102

RE: Support passage of SB 923 and update Workers' Compensation Fee Schedule

Dear Ms. Baker:

I respectfully request you to immediately review and update your fee schedule for primary care services by supporting the passage of SB 923. As an advocate for injured workers and all workers, I continually fight for legislation that will improve the quality of life of workers. I believe SB 923 will increase access to quality health care to California's injured workers.

Updating your fee schedule for workers' compensation will help improve access to high quality medical care for California workers injured on the job by retaining high quality primary care physicians. Implementing a Resource Based Relative Value Scale (RBRVS) system, as proposed in SB 923, will control increasing costs and unnecessary medical expenses incurred by some physicians.

By reducing medical costs and increasing delivery of quality medical services in the state's workers' compensation system, SB 923 will benefit all of California's injured workers. Reducing costs associated with the state's workers' compensation system also saves money for the State and taxpayer. SB 923 is a win/win for injured workers, the California economy, and the state budget!

SB 923 appropriately leaves the details of the RBRVS conversion, the selection of billing ground rules and coding guidelines, geographic adjustments, and other details to the regulatory process -- where they can be sorted through the deliberation and the input of stakeholder expertise.

I urge your support and leadership. Thank you for your consideration.

Sincerely,

Michael Kennedy SJ

Rev. Michael Kennedy, SJ
Executive Director

April 23, 2012

To: Christine Baker, DIR Director
Rosa Moran, DWC Administrative Director Rosa Moran

From: Associated Builders and Contractors Golden Gate Chapter (ABC GGC)

Re: Workers' Compensation Public Forums
Written Testimony

This letter is in response to the request from the Department of Industrial Relations (DIR) and Division of Workers Compensation (DWC) to provide input on the current issues in the Workers' Compensation System in California. The Associated Builders and Contractors Golden Gate Chapter (ABC GGC) seeks here to provide that input to the DIR/DWC, because representatives of ABC GGC are unable to attend the DIR Forums in person to speak. After discussion with a council of our members, ABC-GGC provides the following input on perceived deficiencies in our current Worker's Compensation system in California and hopes that DIR/DWC will work to develop solutions that benefit both the employers in this state as well as the workers:

- The Panel QME process has slowed significantly and getting a panel of doctors is taking several months, thus substantially delaying claim resolutions.

- Panel QME doctors are often deficient in the quality of the reports they provide and do not comply with the reporting requirements contained in the California Labor Code. This deficiency results in multiple supplemental report requests, and/or depositions to secure the information needed to resolve claims, including addressing permanent disability levels in accordance with AMA guidelines, apportionment, etc. As a result, claim resolutions are significantly delayed and medical costs increase due to the multiple billing for each supplemental report.

- Treating physicians are prescribing more medications now for the same diagnosis than they did prior to reforms. This increases claim costs and compounds the claimed medical conditions due to the side effects of the prescriptions. When questioned, the physicians simply give the employee total disability rather than identify specific physical restrictions that would then allow an employer to implement a successful Return to Work program for the claimant.
- There is no accountability for Treating and Panel Physicians for their outcomes or quality of their care and evaluations. Treating Physicians have no accountability for the results of their care. Panel Physicians have no accountability to the timelines for reporting set forth in the California Labor Code, nor do they provide legally admissible reports. Yet they expect their invoices to be paid in full and on time.

- It is too easy to file ancillary claims for psyche, mental, and sexual dysfunction disorders in order to significantly increase the potential settlement value of claims. Defendant Insurance companies will often escalate settlement values to avoid the delays and medical/legal costs associated with a new round of evaluations to defend these add-on claims, which often arise years after the original claim is filed. This "loop hole" promotes abuse of the system and increases costs.

- Judges, who set EVERY "In Pro Per" case for adequacy hearing and delay resolutions for the most minimal issue, create log jams in the court calendar and create further delays for all Claimants. Some judges disregard medical reports and impose their own opinions as to need for treatment and/or levels of disability or injury as if they had examined the injured employee themselves.

- Worker fraud is running rampant in the worker's compensation system and there seems to be little concern on the part of the system about dedicating resources to combat it. When workers are found to be committing fraud in the course of a worker's compensation claim, there should be stiffer penalties for this behavior, including civil fines and felony convictions. Currently, when worker fraud is revealed, the case is dropped from the system, and no further action is taken. This compels fraudulent workers to continue to attempt further claims in the system as there is no "down-side" to it.

- The experience modification calculation formula is out of balance. Claims of $7,000 or under inflate modification factors too severely. This hurts all employers, but particularly smaller employers who don't have enough payroll to counterbalance the claim. The Work Comp Insurance Rating Bureau should revise its formula to lessen the extreme impact these claims have on experience modifiers.